Donald E. Clemons, M.D.
Robert J. Clemons, M.D.
Steve L. Peterson, M.D.
Melissa K. Taylor, PA-C
Zarema Carrier, FNP
George B. Winton, M.D.
Paul M. Benson, M.D.
Timothy L. Gardner, M.D.
Andrew W. Hull, PA-C

Dear Patient:

We are excited about serving you with the best dermatology care. We wish to welcome you as a new patient to our practice. We have taken great pride in serving dermatology patients in the area for approximately 20 years.

In order to help us better serve you we have provided for you a *Patient Information* sheet and our *Disclosure of PHI Form*, both to be completed in full before you arrive.

Please make sure to sign and date all documents.

****If the patient is a minor,** also included in this packet is a ***Treatment to Minors Form.*** Please list anyone, other than parent or legal guardian that would have permission to bring the patient. If the patient is old enough to bring themselves, list the patient on the form as well.

****If your insurance requires a referral to see a specialist it is your responsibility to contact your primary care office to request an insurance referral be faxed to our office prior to your appointment time.****

PLEASE NOTE: It is Urgent that you have the forms completed and have the following information with you:

1. **INSURANCE CARD**
2. **ANY NECESSARY INSURANCE REFERRALS**
3. **A FORM OF IDENTIFICATION preferably -with a picture**
   Or- government identification with your current address or a current bill that shows your current address.

If you do not have these items it could result in a delay of your appointment.

PLEASE BRING A LIST OF ANY MEDICATIONS THAT YOU ARE TAKING TO YOUR APPOINTMENT

Sincerely, Tri-Cities Skin & Cancer

TRI-CITIES SKIN & CANCER

1009 N State of Franklin Access Rd • Johnson City, TN 37604
Telephone (423) 929-SKIN (7546) • Fax (423) 929-7968

PHI Disclosure

I understand that my health information is private and confidential. I understand that Tri-Cities Skin & Cancer works very hard to protect my privacy and preserve the confidentiality of my protected health information, (PHI).

I understand that signing this document means that Tri-Cities Skin & Cancer may use and disclose my PHI to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in physician declining to treat me.

Tri-Cities Skin & Cancer has a detailed document called "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Tri-Cities Skin & Cancer may update this "Notice of Privacy Practices". If I ask, Tri-Cities Skin & Cancer will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Tri-Cities Skin & Cancer to restrict how my PHI is used or disclosed to carry out treatment, payment, or health care operations. I understand that Tri-Cities Skin & Cancer does not have to agree to my request. If Tri-Cities Skin & Cancer does not agree to my request, I understand that Tri-Cities Skin & Cancer would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Tri-Cities Skin & Cancer may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that Tri-Cities Skin & Cancer can give me called "Revocation of Consent for Use and Disclosure of Health care Information", or

2) Writing, signing, and dating a letter to Tri-Cities Skin & Cancer. If I write a letter, it must be say that I want to revoke my consent to authorize the use and disclosure of the patient's PHI for treatment, payment, and health care operations.

I understand if I cancel this consent, Tri-Cities Skin & Cancer does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Tri-Cities Skin & Cancer's "Notice of Privacy Practices".

_____ _____

Patient or Legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.

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TREATMENT TO MINORS FORM

Many times parents find themselves unable to accompany their children to their appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Tri-Cities Skin & Cancer Permission to treat my child in my presence an when they arrive at the office unaccompanied.

Pleas list others who may bring your child without your presence:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

Patients Name: _____

Date of Birth: _____ Chart Number: _____

_____ _____

Signature of Parent Date

_____ _____

TCSC Representative Date

*** Please be aware, this form must be updated yearly***

**** Verbal Consent Obtained Yes: ☐ No: ☐ ****

_____ _____

TCSC Representative Date

_____ _____

TCSC Witness Date

Tri-Cities Skin & Cancer
PATIENT INFORMATION

Please write clearly…

Patient Name: _____
First Middle Last

Address: _____ _____ _____ _____
Street/Apt # City State Zip

Phone: _____ Birth Date: _____ SS #:_____ Email: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widow

Primary Care Physician: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Please complete if patient is a minor…

Father/Guardian: _____ Mother/Guardian: _____

Employer: _____ Phone: _____ Employer: _____ Phone: _____

Responsible Party: ☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian

1. Primary Insurance: _____

Insured's Name: _____ Birth Date: _____ SS # : _____

☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian CoPay Amount: $_____

Member ID #: _____ Group # or Employer Name: _____

Claims Address: _____PLEASE BRING COPY OF CARD_____ Phone:_____

2. Secondary Insurance: _____

Insured's Name: _____ Birth Date: _____ SS # :_____

☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian CoPay Amount: $_____

Member ID #: _____ Group # or Employer Name: _____

Claims Address: _____PLEASE BRING COPY OF CARD_____ Phone:_____

MEDICARE PATIENT

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Date Signature of Patient or Parent if a Minor

OTHER INSURANCE:

I authorize payment of insurance benefits, otherwise payable to me, directly to (Practice Name)

_____ _____
Date Signature of Patient or Parent if a Minor

*Authorizations: I give my consent ☐ Yes ☐ No – to have medical care including labs and test results, medications, diagnosis and treatment discussed with the following person(s):_____